STUDY OF THE IMPLEMENTATION OF OMH'S BILINGUAL/BICULTURAL SERVICE DEMONSTRATION PROGRAM

EXECUTIVE SUMMARY

Contract #282-96-0019

August 17, 1998

Submitted to:
Division of Policy and Data
Office of Minority Health
U.S. Department of Health and Human Services
Rockville, MD 20852

Submitted by:
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Study of the Implementation of the OMH Bilingual/Bicultural Service Demonstration Grant Program (FY 1993-1995)

SUMMARY OF OMH BILINGUAL/BICULTURAL SERVICE DEMONSTRATION GRANT PROGRAM

The present study covers the first three series of grants (FY 1993-95) under the OMH Bilingual/Bicultural Service Demonstration Grant Program, encompassing 62 projects, for a total value of $4.75 million. In FY 1993, 12 projects were funded for one year each; in FY 1994, 35 one-year projects were funded; in FY 1995, 15 three-year projects were funded and are slated for completion in Fall 1998. The projects were located in 19 states and the District of Columbia and American Samoa. The grant program was intended, by Congressional mandate, to improve health care access for minority populations of limited English proficiency (LEP), and to build the capacity of community based and other organizations toward this goal.

The study summarized below is a first attempt to gather comprehensive information about the implementation and impact of the OMH grant program. It has been carried out in two phases. Phase I involved the administration of a Mail Verification Survey and a Follow-up Telephone Interview to a sample of 32 of the 47 projects funded in FY 1993 and FY 1994. Phase II involved site visits to nine of the 15 FY 1995 (3-year) grantees. Study protocols were developed with the assistance of an Advisory Committee of experts and practitioners in minority health. For Phase I, clearance was required, and obtained, from the Office of Management and Budget (OMB) under the Paperwork Reduction Act. The study collected data in response to eight policy and programmatic questions (referred to as "domains"):

DOMAIN ONE: Did the program help build the capacity of community-based organizations to address access to health services for limited-English-speaking minority populations?

DOMAIN TWO: Did the program increase the capabilities of health care professionals to address cultural and linguistic barriers to effective health care service delivery?

DOMAIN THREE: Did the program increase access to health care for limited-English-speaking minority populations and their knowledge of and ability to negotiate the health care system?

DOMAIN FOUR: Did the program increase consumer knowledge of preventive health?

DOMAIN FIVE: Did the program serve as a catalyst to develop or change existing health policies at the community level?

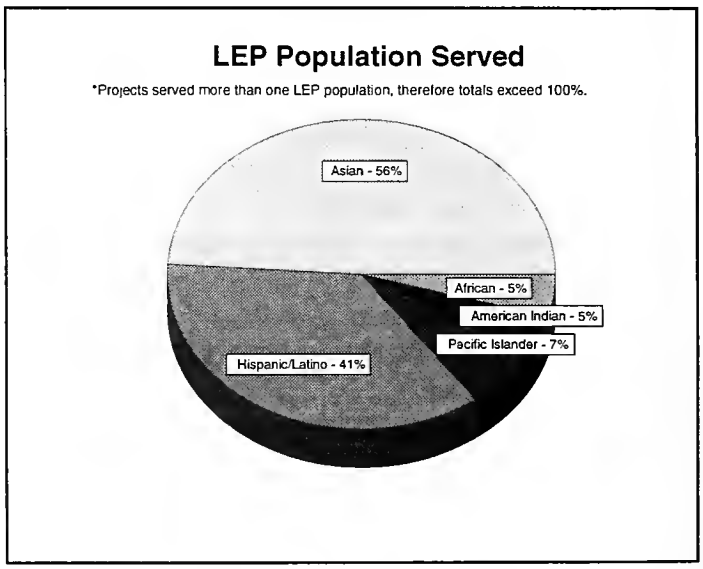
DOMAIN SIX: Did the program findings and/or outcomes influence State/Federal policies targeting limited-English-speaking minority populations?

DOMAIN SEVEN: Were specific methods of implementation more effective than others? What methods were most effective in creating and sustaining linkages between a project and other organizations within that community?

DOMAIN EIGHT: What are the main components of an effective program?

The following sections of this Executive Summary summarize results from all grants studied in both Phase I and II, discuss common program implementation issues, and conclude with recommendations for the program as a whole.

SUMMARY OF GRANTEE CHARACTERISTICS



The vast majority of the 32 projects (29, 91%) operated in urban locations. Another seven (22%) were located in rural areas and three (9%) in suburban areas. In addition, some projects operated in more than one type of location. Ninety percent of the grantees were nonprofit organizations; 5% were county health departments, and 5% were tribal governments. The target populations tended to be more disadvantaged than the community as a whole. Asians were the group most frequently served by all projects (56%), followed by Hispanic/Latinos (41%), Pacific Islanders (7%), American Indians (5%), and Africans (5%). There were more than 14 specific ethnic groups served among the Asians, most frequently Cambodian/Khmer, Laotian, and Vietnamese, Mexicans and other Central Americans, and Salvadorans were the groups most frequently served among Hispanic/Latino populations.

Forty-three languages were spoken by the target populations served. Most frequently, these were Spanish (41%), Lao (39%), Vietnamese (39%), Khmer (34%), Chinese (22%), Hmong (20%), Thai (17%), and Tagalog (15%).

Two-thirds of the grantees served target populations of all ages (adults and children). For more than two-thirds of the projects, the OMH-funded activities were new to the grantee; for the remainder, the activities were an expansion of existing grantee activities (OMH-sponsored or in-house). More than half (53.3%) of the projects reported that project staff needed additional training to carry out project activities.

Needs assessments were conducted by 37 percent of the projects. With respect to accessing health services, projects identified more than a dozen barriers facing their target populations. Most frequently cited were:

- language/lack of translation materials and lack of language-appropriate information, signs, or brochures (95%),
- lack of awareness among target population (78%),
- lack of awareness among providers (76%),
- differences between target population's health practices and mainstream health practices (66%),
- lack of health insurance or other benefits to cover costs (59%), and
- lack of money for medical expenses, transportation, and other costs (59%).

Projects identified an average of three goals and seven objectives each, for a total of 107 goals and 310 objectives. There was wide variation. Some projects proposed many more, with one project recording 14 goals and another 20 objectives. Of all objectives, 211 (68%) were fully achieved; 69 (22%) were partially achieved, and 12 (4%) were not achieved. For 18 objectives (6%) the achievement level was not available. Analysis showed that projects were more successful in fully achieving objectives that involved capacity building and the development and dissemination of materials than in achieving those that involved education and training and service delivery. Generally, the inclusion of unrealistic numbers of goals and objectives was an implementation problem that should be addressed.

HEALTH ACCESS NEEDS

Beyond the health needs identified by project proposals or needs assessments, interviews and focus groups conducted in Phase II provided excellent insight into situations and predicaments faced by LEP minority populations when trying to access health care.

Projects focusing on interpretation issues identified the following:

- ***Burgeoning populations of LEP minorities, with limited capability within the local health/social service provider system to handle the situation.*** Very few hospitals/providers in the grantee service areas had sufficient interpreter services to handle the caseload. For example, a children's clinic that was open in the evening noted that 40 or more monolingual, Spanish speaking clients might come in on a typical evening, yet often no one was available to interpret. This forced the clients to rely on several bilingual staff solely. Some providers had access to networks of on-call interpreters, but these were typically untrained in medical terminology, and not always available. Or, where there was some on-staff capability, the

interpretation services were not available at night/24 hours, creating a problem with respect to off-hour emergencies. A typical practice for providers, when the need for interpretation came up, was to *pull almost any available employee* (even, for example, from the hospital cafeteria) who was a speaker of the necessary language. Again, however, these individuals were not trained in medical (or any) interpretation. Finally, providers would often ask the LEP patients to bring their own interpreters -- most commonly a family member. In this situation, not only is lack of training a factor, but inappropriate matches occurred (e.g., a child ends up as interpreter for an adult). "How," asked one grantee staffer, "is an 8-year-old going to know the terminology for family planning?".

- ***Problems of wasted time, delays in care, and confidentiality.*** Providers, when they used their own staff (not staff who were interpreters) to interpret, found considerable problems of inefficiency and wasted time: time necessary to fill in for a staff member while he/she was diverted for interpreting, or the time wasted in trying to serve an LEP patient without interpretation. In addition, enormous confidentiality problems result if untrained staff or family members interpret. Consider, for example, using such informal interpretation to discuss an STD, a situation involving the exchange of very sensitive information between the doctor and patient. Finally, if a patient does not understand what he/she must do regarding a particular treatment protocol, valuable time may be lost and efforts duplicated. For example: an LEP patient does not understand that before surgery, no food or drink (other than water) may be taken for a specified period. If the patient comes to a scheduled surgery without having followed this regimen, the surgery must be canceled and rescheduled.

- ***The danger of misdiagnosis, and miscommunication regarding treatment.*** If patients cannot effectively communicate their symptoms, the danger of misdiagnosis is high. Moreover, treatment compliance is seriously affected; if medication is prescribed, for example, and the patient does not understand proper dosage, serious consequences can result: In one reported incident, a monolingual Hispanic woman had a 10-year-old cousin who went to the emergency room with a throat problem. She was given Tylenol. Her parents kept giving her more and more Tylenol, not understanding the dosage instructions. The girl then died of liver failure due to an overdose of Tylenol.

For grantees who provided target population education/outreach, materials development and client advocacy, other needs existed:

- ***Lack of awareness among the LEP population with respect to diseases and available services/treatment.*** Among one Cambodian community, for example (particularly among older Cambodians), awareness about cancer, its causes, and prevention was very low. Conducting breast self-exams was a difficult concept for Cambodian women. Many men who had been smokers since they were young boys in Cambodia—where boys smoke both because it has "cachet," and because it keeps the mosquitos away from self and livestock—had similar trouble with prevention strategies.

- ***Unfamiliarity with the health care system, and culture-specific knowledge about health.*** In particular, many LEP populations are unfamiliar with the general concept of prevention,

including both lifestyle factors and preventive medical care (e.g., pap smears). It is most common to go to a doctor when the symptoms are already present, which, with cancer, may be too late. Moreover, treatment from home-country doctors may consist of pain reduction or symptom reduction, as with many Chinese/Southeast Asian herbal remedies for cancer. Also, these doctors may themselves be unfamiliar with the network of specialists available. LEP populations are also generally unfamiliar with the complex process of obtaining health care coverage in the United States, from paperwork, to billing, to multiple appointments in, perhaps, different clinics. Added to this is the process of obtaining appropriate health insurance coverage, again requiring the filling out of forms. Finally, many LEP patients are accustomed to a traditional role for doctors as authorities, and are thus not used to "talking back" or asking questions to doctors.

- ***Fear and mistrust based on experiences in the home country, during migration, and in the United States.*** This was a key factor, particularly for Southeast Asian and Central American LEP populations. With respect to Southeast Asian populations, many are coming from an experience of repression, war, and nightmarish escape histories. So, before being able to understand the particulars of the health care system, it is first necessary to establish a basic sense of trust; during one site visit in the San Francisco area, Cambodian seniors already living in "deplorable" conditions were afraid that the site visit team was there to take away what already few public benefits they received. Central American migrants commonly report a fear that if they use the health care system, their "papers will be taken," or they will be "found out" by the INS. They also are concerned that if they use public health services, they will lose their jobs or their right to become citizens. Generally, there is a fear of authorities, or "fear of uniforms."

- ***Lack of relevant health education materials.*** While there are some health education materials available in Spanish and other languages, target LEP populations for the FY 1995 grantees encountered circumstances in which only limited materials were available. First, many target population members were non-literate in their own languages, therefore, even if written materials were available, they would have been of little use. Second, some projects worked with populations speaking a broad range of languages for which few, if any, materials were available. For one project, these languages included Fulani, Wolof, Mandingo, Amharic, Bambara, and others from sub-Saharan Africa. Third, there was a need not only for health education materials in languages other than English, but for more basic items, such as medical intake forms, billing or public assistance forms, and the like.

- ***Insensitivity of health care professionals.*** One of the most common complaints by LEP population members was that American doctors tend to be brusque, impersonal and/or unaware of many interpersonal cultural issues. For example, Hispanic/Latino clients, particularly women, are very uncomfortable when a doctor does not ask about her family, how they are doing, or other rapport-building interactions. LEP patients even reported subtle gestures, such as when doctors made eye contact only with the interpreter, and not them. Southeast Asian women, and Hispanic/Latino women, also are uncomfortable disrobing—even for an exam such as a mammogram. In addition, some doctors ignore or are unaware of traditional health remedies that their patients may be taking/doing in parallel. Hispanic/Latino patients, for

example, have in their home countries a wide access to drugs and other medicines that would be available in the U.S. by prescription only. If doctors do not ask about this, they may prescribe a medicine for the patient that conflicts with something they are already taking. There were other situations as well: one Hispanic transgendered individual, for example, reported that health professionals refused to call him by his (preferred) female name. Moreover, *insensitivity was not just attributed just to American doctors*. Many complaints were voiced by Southeast Asian women about doctors from their own countries who ignored or invalidated women's reports of symptoms as a product of irrationality, emotionalism, or even as a threat to their authority. Recently-immigrated Hispanic clients sometimes experienced resentment from Hispanic health professionals who were longtime U.S. residents (who spoke English), or of different class or national origins.

> *"Sometimes health care providers are simply unaware or insensitive to what they put patients through. In one example, a 70-year-old Hispanic woman had pains in her head around 11 p.m.. She went to the emergency room, and was told that because 'she had no papers' she would have to wait until the head nurse came in at 8 a.m.. She ended up staying two nights in the emergency waiting room."*

There were also several general issues faced by grantees as part of the setting within which they had to operate:

- ***Poverty, non-literacy and immigration issues among the target LEP population.*** Many target populations for the OMH grants were refugees and/or migrants, who came from rural areas and situations of civil war, or from situations of serious poverty, and who also are non-literate in their own language, do not have transportation, and are mistrustful of authorities. This is particularly true with respect to undocumented immigrants.

- ***Increasing presence of managed care in the public health domain.*** More public health or Medicaid services are being provided through managed care arrangements. With respect to LEP populations, this becomes very important because the managed care contracts are governed by *performance standards, or standards of care.* In order for these populations to be well-served, the performance standards need to include language and cultural competency elements. It also puts pressure on existing community-based health providers, or other public health providers, to compete with the managed care organizations that are coming in to "bid for their customers."

- ***Bureaucratic rivalries/"turf" issues.*** Site visit grantees based in public health agencies faced issues unique to that setting. For one, there tended to be departmental rivalries -- sometimes along ethnic lines -- that served as impediments to program implementation. When a new program is instituted in one department, individuals in other departments who may have been involved in (even limited) provision of those services feel threatened. At times, factions form, potentially undermining the effectiveness of the "new" activities. Thus, if OMH funds interpretation services, and some limited interpretation is being done (albeit without training or structure) by others in the same organization, these individuals may not cooperate with the new services. It was also clear that *implementation in such cases is greatly aided by the enlistment or cooperation of at least one high-level individual—where this occurred, many implementation barriers were overcome; where it did not, they remained.*

- ***The politics of ethnicity in the community.*** Unfortunately, the competition for grants and services, especially in the current environment of limited public dollars, produces competition and rivalries by ethnic group. The resulting politics can impede program functioning in the bureaucratic setting for agencies serving diverse, racial/ethnic constituencies. Thus, if one group might be getting funds, others may develop resentments that the needs they face are either not understood, are being ignored, or that they are not "in favor" at the moment.

- ***Union issues.*** Though the site visit staff encountered this issue in only one site, it is likely to be a factor in other sites as well, where a grantee is a large public health agency. The issue centered on how to treat staff whose capabilities increased due to participation in a language and cultural awareness course. Should the position be classified differently? Was the agency authorized to use them or place them at any clinic it wanted (where the perceived need was) due to their new skills? How was this to be regulated? Ultimately, these kinds of questions were resolved when the union was brought into the process of developing a certification process for bilingual staff.

SUMMARY OF MAJOR IMPACTS -- PHASES I AND II COMBINED

The OMH Bilingual/Bicultural Demonstration grantees were funded to step in and address the kinds of situations described above. Given the funding limitations, these projects achieved some notable impacts. Moreover, we cannot leave out the human element -- many of these community projects are staffed by people who have a tremendous dedication to their work and to their community. This in itself is a resource which should be given ample credit.

Building capacity: During and after the grant period, just over one-fifth of the grantees in the study sample generated additional funds to supplement OMH support in carrying out their project's activities. Over half the Phase I grantees reported that the activities developed with OMH funds were continued beyond OMH funding, thus these projects served as ongoing resources in their local communities. Nineteen percent of the Phase I grantees reported that specific policies or procedures had been adopted as a direct result of OMH grant activities. The new policies/procedures adopted by those organizations included things such as:

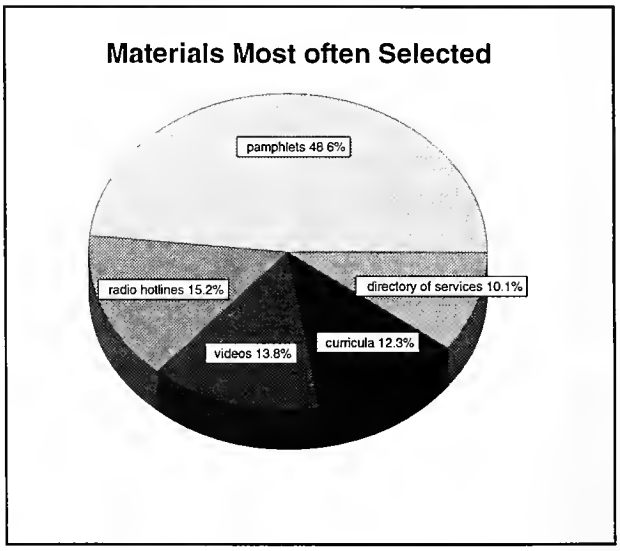
- requiring staff training,
- developing long term plans for integrating cultural competency into all aspects of the organization,
- developing a culturally acceptable tribal plan for the long-term delivery of HIV/AIDS and related health risk education, and
- establishing the procedure that all emergency-room referred clients receive a clinic reminder call for follow-up treatments.

Twenty-eight percent of the Phase I grantees reported that either their organization or staff from their organization had become involved in community coalitions or committees as a result of the OMH project. Thirty-one percent of Phase I grantees reported that because of OMH funding, activities developed during the grant project had been integrated into other programs. For some, this meant that curricula developed with OMH funding continued to be used and was adopted by other

organizations in the community. Staff training continued in some sites. In other sites, the use of translation services by hospitals and health care providers increased.

In addition, many grants -- particularly the longer three-year grants (sampled in Phase II) -- built reputations in their communities, and even at the statewide level sometimes, for providing/advocating LEP minority health services. Some grantees became known resources: "if you need help with interpretation, you can go to (PROJECT)." Staff capabilities and links to the community were typically strengthened as well, an effect more pronounced with longer grants. Several projects served as pilots, in the sense of leading to more expanded funding or incorporation into other activities.

Increasing Provider Awareness and Capacity: For all OMH Bilingual/Bicultural grantees sampled in Phase I and II, approximately 5,068 health care professionals have participated in training for providers (by end of FY 1995 grant period). Forty-seven types of training were held for health care professionals, most often for doctors, nurses, and community health workers. Other health care workers who were trained included health educators, outreach workers, physician's assistants, interpreters, midwives, case managers, emergency room staff, and many others. In addition 12 other types of trainings were held for interpreters and others.



Projects developed and/or adapted a total of at least 186 distinct types of materials, most often pamphlets, radio spots, videos, curricula and directories of health care and social services staff.

In addition, other key impacts reported in this domain included: positive changes in health provider attitudes with respect to serving LEP patients; increased provider knowledge of specific cultural circumstances (refugee experiences, traditional health practices); increased provider knowledge of and capability to work with interpreters; and increased provider ability to handle emergencies and crises with LEP populations. As Phase II projects are completed, more impacts of this nature may occur.

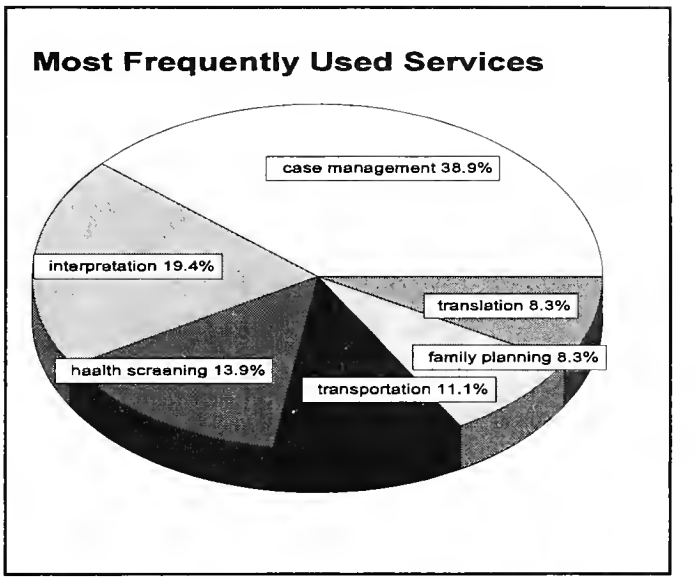
Increasing Access to Services: The OMH grantees did not provide direct medical services (treatment) per se. Many, however, provided intermediate or enabling services designed to move LEP individuals into health care -- case management, health screenings, outreach and referral, and language interpretation are examples. The use of the term "services" in this report refers to these kinds of enabling activities.

For the combined Phase I and II sample of grantees, a minimum of 13,035 LEP clients received (intermediate) services that increased their access to direct medical services. These services most often included case management, interpretation, health screening, transportation, access to family

planning, and interpretation, and others that served as the entry point for direct medical services.

As described under the next domain, increases in LEP population awareness (about prevention and health) and ability to negotiate the health care system also increased access to services. This occurred *because LEP individuals are more likely to be proactive and seek services where they would not have before, particularly for preventive care such as prenatal checkups.*

Increasing LEP Population Awareness About Health Prevention and Knowledge of The Health Care System: This was probably one of the strongest impact areas for both Phase I and II grantees. LEP population awareness was increased through a wide range of specific activities, including outreach, health fairs, education sessions, home visits, and other modalities. It was also increased via the often close interactions between patients and interpreters, or between patients and health educators. LEP clients often had to rely on these individuals for a great deal, and to discuss highly personal or confidential issues with them. In addition, LEP clients often reported an increase in confidence about how to obtain care, and on what it means, for example, to have a mammogram. These impacts are difficult to measure quantitatively, but they were commonly reported where the question format allowed for open-ended explanation -- particularly during site visits to the Phase II (3-year) grantees. While the site visit format allowed for much more data of this type, similar impacts, on a smaller scale, were also reported for the FY 1993-94 (Phase I) grantees.



Impact on Policy: The impact in this domain varied by length of the grant. The FY 1993-94 grantees were not in place long enough to make any policy impact outside their programs or immediate surroundings. On the other hand, the FY 1995 grants have thus far shown more policy impact at the local and sometimes state level. This impact came in the following ways:

- Changing procedures and policies of local or regional health providers—usually to incorporate bilingual designations or requirements for employment and/or staff advancement, thereby institutionalizing the necessity of language competence.

- Through participation in task forces, commissions, and other deliberative bodies, involvement in the development of standards or guidelines for cultural and linguistic appropriateness in health care. *This is a key area in which OMH and its grantees could have a more visible impact.*

EFFECTIVE PROJECT COMPONENTS AND STRATEGIES

As elaborated further in the full report (Chapter V), the OMH grantees have developed a rich variety of strategies and approaches for addressing health access needs of specific LEP populations. The experience of these projects is an enormously useful resource in support of further efforts in the field. Moreover, the implementation of these projects has resulted in significant data on effective implementation strategies and project components. A selection from Phase I and II projects are highlighted below:

What Are Keys to Successful Project Implementation?

- ✓ Simplicity helps effectiveness. Study results indicated that projects were more effective when program scope was realistic; when the number of goals/objectives, number of services provided, or number and variety of communities served was kept to manageable levels. Otherwise, it is too easy to become overextended, because the process of working closely with specific communities is time consuming.
- ✓ Consistent attention to evaluation is difficult for small, community-based programs. In this respect, agencies can benefit by developing a permanent relationship with a local college or university to assist with ongoing evaluation and needs assessment.
- ✓ Resource and other limitations can be a barrier. In this study, projects that attempted to link with local task forces, health organizations, community health coalitions and hospital committees leveraged more resources.
- ✓ Staff retention can be an obstacle for small community-based programs: Projects need to be creative in recruiting and retaining qualified staff who are bilingual, such as developing nonmonetary incentives for staff who are qualified and have an adequate health background.
- ✓ For the OMH program as a whole, it was apparent that sequential funding of grants can help build a cumulative expertise at the grantee organization; for example, a video developed in one year can be used as a training vehicle in subsequent years -- as part of a subsequent grant to the same organization for training.
- ✓ Generally, projects are effective when they have credibility, respect, and presence in the community. There is no shortcut for this -- it takes time, and requires consistency.
- ✓ The credibility of community program staff can be a key factor in relationships with providers; therefore, projects need to take advantage of any opportunities to obtain certification or professional designations for medical interpreters and other staff.
- ✓ Public health agency grantees will often have to address a range of bureaucratic obstacles. Project experience strongly suggests the need for such grantees to enlist the cooperation of a top-level representative who can broker departmental rivalries. This person is crucial in obtaining resources and overcoming turf issues.
- ✓ Many activities involved in increasing access to health care for LEP populations are complex and labor-intensive. Project or program directors, if unable to devote sufficient time to these activities, should designate a dedicated project coordinator to the project to handle the multiplicity of day-to-day activities.
- ✓ Training is best when it is not a one-time event: programs for health provider staff are most effective if they are followed up by booster sessions or other followup activities.
- ✓ Program staff working with clients concerning serious diseases such as HIV/AIDS and cancer should have crisis training, because they are often called upon to handle such situations.

What Were the Most Effective Program Components?

✓ Generally, the use of interpreters was highly effective in responding to the LEP population's need to obtain health services -- particularly since, for the most part, interpreters also tended to serve as client escorts, advocates and health educators.

✓ While interpretation services were effective, a common obstacle concerned the relationship between interpreters and health providers; some projects addressed this by offering interpreter training that sought to include both providers and interpreters to foster communication and rapport.

✓ Components tailored to the needs of specific populations worked well: For example, home visitation was the most effective method of health education for Southeast Asian women.

✓ Personal relationships are essential in promoting successful health behavior change with LEP populations; projects that utilized health educators and interpreters who regularly accompanied patients through the process were most effective in engendering patient awareness and confidence in negotiating the health care system.

✓ Health provider staff training program components often encounter problems of attendance and resistance: These were minimized when training for health care providers was incorporated into the job requirements and attendance was required and paid for.

✓ Projects that trained health care providers on cultural awareness and interpretation also faced resistance. Adding a marketing component was one strategy that proved effective. Such a component could employ newsletters or other information sent to providers that:

- raises provider awareness of the pitfalls (and potential liabilities) of mistranslation and language barriers, and
- outlines the links between cultural beliefs and health behaviors.

✓ Increasing awareness through media materials was useful, especially when tailored or targeted to specific situations. For example:

- radio spots may reach a wide audience in a cost-effective manner, and
- videos may be most effective when used with a trainer in smaller, interactive sessions.

✓ For study grantees, capacity building activities and materials development/dissemination were more successful in meeting project goals and objectives than activities focusing on education, training and service access. However, this may mean that more resources and technical assistance may be required to successfully implement these latter services, or that project goals in these areas tended to be unrealistic.

COMMON IMPLEMENTATION ISSUES AND BARRIERS

Both Phase I and II grantees experienced many common implementation barriers. These included:

- **Difficulties in finding and retaining bilingual staff who were also qualified as health educators, interpreters, etc.** Many projects in all grant years experienced difficulties in recruiting and retaining staff at all levels to carry out their LEP projects, which often led to delays in implementing project activities. Staff for these projects require a complex mix of background and training. This problem was described eloquently by the respondent from a grantee health center: "We had difficulty in recruiting candidates that were equally qualified in language and cultural competencies. It was necessary to find candidates who were comfortable in their ethnic language as well as English, were acceptable to their community as a bridge between western medicine and traditional practices, and felt comfortable educating members of their ethnic group and western medical providers." Besides the cultural and language requirements, many of these projects required staff who also had significant subject matter expertise. A community center working with Southeast Asian immigrants found it "extremely difficult to find a person who has both community ties and a health background. There are few health professionals and paraprofessionals in the Lao and Cambodian communities; of them, most are totally overextended." Finally, a grantee in New York noted that finding all these qualifications in someone who also has no unresolved immigration status issues is even more difficult. But cultural competence of staff is key, explained another grantee: "This element of cultural competence, then, is central to success, since refugee families are won over to this system by the feeling that there is someone who truly understands them in the care system, and that this knowledge will carry some weight in the overall care system by which the patient is served."

- **Low salary levels.** For many projects, low salaries were a significant barrier to hiring qualified staff, once they had been identified, or retaining qualified staff for the entire grant period. As the respondent from an Asian Pacific Islander project pointed out ...." truly bilingual/bicultural Asians are easily able to find jobs with much higher pay and benefits while those interested in this wage range tend to be limited in English proficiency." A community center unsuccessfully attempted to address this problem by giving employees stipends for language abilities. The respondent from the center reported that ..."the incentive program was not effective for retaining bilingual staff. The amount of money ($500 for full-time employees) was deemed insufficient to make a difference in an employee's decision of whether to stay at the center or seek employment elsewhere. Comments from Hispanic staff members indicate that a separate (higher) salary scale for bilingual employees would be more effective than a stipend."

- **Evaluation.**This is, of course, a perennial problem with small CBOs which have their hands full with the day-to-day needs and crises involved in operating such an organization. Projects serving limited English-speaking populations may face another layer of difficulty in program evaluation. As a grantee staff member pointed out, "we found that Asian seniors had trouble understanding the concept of evaluation. We had to educate them about what evaluation is."

Clearly, to overcome some of these misunderstandings, simple, clear forms, standardized and translated would be recommended, along with a higher degree of monitoring and technical assistance for evaluation.

In addition, certain kinds of evaluation modalities, such as customer satisfaction questionnaires, do not reflect experience: Asian participants may be reluctant to provide any negative opinions on program activities "because of their tendencies to achieve group consensus, harmony, and moderation." An API project needed to have a community leader explain to the group the purpose for the evaluation. Generally, evaluation can be a controversial process, especially in immigrant communities. "Providing health care to refugees is often a socially and politically charged issues, especially when we are dealing with low income populations. We could not subject providers to too rigorous questioning about their practices toward refugees without some declining to participate out of fear of community response." (A small community association).

Finally there is the issue of resources and time. Many projects sampled in Phase I and II did not have sufficient staff time or expertise to conduct evaluation, or did not have computer software and other basic technologies. So, data was collected haphazardly, or collected by hand. Some projects retained outside evaluators, but these relationships did not always remain stable throughout the grant period. The most successful evaluations used in-house expertise and collected data and maintained records routinely. Others had established a good, ongoing relationship was established with an outside evaluator, for example, at a local university.

- **Funding and length of project.** This was much more of an issue with the FY 1993-94 grantees than with the current (FY 1995) grantees, for obvious reasons. One year grants are simply not enough time to attempt to address the broad needs faced by LEP minority communities. Simultaneously, since needs and expectations are high, many projects try to do too much in that short period. What did prove useful, however, is that some projects developed items (such as a video) under the one year grant, and then used them in a follow-up grant or as the basis for an expanded activity. In such cases, the one-year grant was akin to "prototype" development funding.

- **Grantee - OMH relationship.** While often this relationship was problem-free, a commonly-expressed sentiment was that projects experienced a general lack of involvement by OMH, either to provide guidance or technical assistance, or to monitor progress. More direct and ongoing interaction would have been beneficial. One grantee expressed disappointment that the project meeting funded under this initiative was not held. This grantee said that such a meeting could have oriented staff unfamiliar with administrative regulations and policies of OMH grants. Another grantee suggested that the reporting requirements (four quarterly reports plus a final report) were burdensome for a 12-month project and that reports at six and 12 months might be adequate. Finally, another grantee reported a misunderstanding with OMH regarding funding and with respect to a small independent research project that was to be conducted at their site.

- **Project structure; too many goals and objectives.** Many projects, under the pressure of funding competition or from lack of experience, created project frameworks that were overly ambitious with respect to goals and objectives. This left no room for the kinds of delays and barriers that almost inevitably arise. Too many goals and objectives burden an overextended staff that may end up worrying about "making the numbers" rather than working through barriers to provide high quality services or products. In addition, many goals/objectives as written are not easily measured, hampering evaluation or rendering evaluation ambiguous.

- **Other issues.** Issues discussed in Chapters II and III, which also arose as implementation barriers include: non-literate populations for whom there were few resources; health provider resistance to trainings; and issues of bureaucratic politics, ethnic competition (regarding funding), and intra-ethnic conflict.

- **Specific cultural issues.** Many culturally-specific implementation issues arose. These included:

  - Support group sessions may not be effective for Asian populations. It is "culturally foreign" to gather with people who are not part of one's own family to talk about personal issues.

  - A wide range of *intra-ethnic conflicts* occurred. These issues were not discussed as often as *inter-ethnic conflicts*, but they present strong implementation barriers. Some examples:

    a) Conflict between Hispanics who have recently immigrated and those who have been in the U.S. for a long time -- this comes up in resentment that the "new immigrants" don't speak English while many long-term residents do, and in other ways.

    b) Conflict between Hispanics of different classes or from different regions.

    c) Conflicts or misunderstandings especially between Southeast Asian health professionals and their patients -- some professionals, especially if accustomed to traditional hierarchical relationships in the home country (in which doctors have great authority), do not expect and are not pleased to experience questions or discussions from patients about diagnosis or treatment issues.

    d) Conflict between Vietnamese and Amerasians -- in one project that had hired a (Vietnamese) Amerasian staff found that subtle and open conflicts and hostilities appeared, based on prejudices against Amerasians.

  - Latin Americans of native Indian descent—Mayans, Zapotecs, Mixtecs and other native Indian peoples from Mexico and Central America— are often classified as Hispanic. This designation is not accurate with respect to language, and these individuals typically do not speak Spanish, or do not speak it well.

- Latino men who have sex with men may be difficult to contact for outreach and education because they do not necessarily identify with the "white" gay community, nor do they always identify themselves as gay.

- Printed materials are not necessarily the best means of imparting information. For Guatemalan Indian peoples and other low literate LEP clients, oral methods (e.g., storytelling) are more effective. Given this, it may be worth assessing the intended audience and utility of the large number of pamphlets produced by OMH grantees.

RECOMMENDATIONS

With respect to increasing access to health care for LEP minority populations, the **OMH Bilingual/Bicultural Service Demonstration Grant Program** has been a significant force at the local, community, and sometimes State levels. While precise impact and process data has been difficult to collect on a comprehensive and consistent scale, impacts over many dimensions have been shown, as outlined in this report. Moreover, it is DSG's strong belief that OMH should exercise more proactive management over program implementation, products, and outputs. If this is done, the Bilingual/Bicultural program could be of substantial assistance to OMH in furthering its larger goals. These include policy development vis-a-vis the range of Federal agencies and organizations supporting the provision of health care to minority populations.

The following twelve recommendations, based on the data collected in this study, are directed toward OMH and are designed to contribute to this process. The first five recommendations relate to specific ways in which OMH could improve the Bilingual/Bicultural program functioning and effectiveness; the other seven recommendations are more comprehensive suggestions for the program and for OMH itself.

RECOMMENDATION ONE:	**Provide Better Technical Assistance to Grantees on Setting Goals and Objectives**

Many grantees wrote too many goals and objectives, hampering their ability to fully achieve any one of them. It is almost a given that implementation problems will arise, and the more flexibility that exists within a particular program, the more resources will be available to overcome the problem. Thus, OMH needs to assist grantees and potential grantees in structuring programs (even at the application stage) that have realistic goals and objectives.

RECOMMENDATION TWO:	**Provide Better Technical Assistance to Grantees Concerning Evaluation**

Given the modest levels of funding, a surprising number of grantees did collect evaluation data of some sort. Much of this, however, was inconsistent and collected in non-comparable or informal formats. This is, in part, an issue of resources. Most community-based programs are so overburdened by their daily challenges that collecting data becomes a "back burner" priority.

Recommendations to address this situation include:

- OMH should consider providing more direct help in evaluation and data collection, or foster arrangements with local colleges/universities;

- OMH should consider giving grantees a tailored database software package, on disk/CD, through which they can enter and process their data in a standardized format, as much as possible, across grantees. Some minimal training on software use also should be provided; and

- If provision of automated software is not a realistic possibility, give grantees a set of data collection forms. *We note that the evaluation instruments developed and used for this study could be a basis from which standardized data collection tables could be developed.*

RECOMMENDATION THREE: Provide More Direct Assistance to Grantees in Dissemination and Networking

OMH could help to share the considerable expertise of its grantees by sponsoring meetings, panels, conferences, and special journal editions, and by *facilitating contact* between grantees and other organizations. For example, OMH could circulate bulletins or a newsletter (to grantees) that feature dissemination strategies and work to improve contact with programs funded by other agencies. OMH grantees also would benefit greatly from opportunities to network *among themselves*, to share best practices, strategies, and resources. OMH could create such opportunities through:

- New and old Project Director technology transfer meetings;
- Annual grantee conferences;
- Better use of Internet technology; and
- Routine conference calls, with groups of grantees, with OMH staff, or with technical specialists where useful.

RECOMMENDATION FOUR: Provide More of a Support/Facilitator Role in Difficult Situations

There were several instances where OMH grantees operating within a large public agency had to confront bureaucratic obstacles and rivalries. These kinds of barriers can be mitigated with a small amount of contact between OMH and a higher-level individual within that agency. Something as simple as a letter on agency letterhead requesting high-level support would be very helpful. When the program has support from a higher-level official, its chances of success are much better. Letting grantees know that OMH support is available, and keeping in regular contact with grantees to be aware of such obstacles, is important for grantee performance. In short, OMH has an important role to play in helping its grantees negotiate the organizational or structural setting within which they must operate. Providing this assistance helps further the overall OMH goal of increasing access to care.

RECOMMENDATION FIVE:	Develop and Disseminate a Best Practices Document for Bilingual/Bicultural Health Care Access Programs

Using some of the information contained in this report, a Best Practices summary could be developed and disseminated to OMH grantees and other programs serving similar populations. The OMH projects reviewed in this study provided a wealth of information about strategies that work and those that do not work.

RECOMMENDATION SIX:	Consider a Mix of Grant and Contract Types That Make Better Use of Resources

Given the problems many grants had in finding and retaining staff, as well as problems concerning adequate funding, it may serve the overall program well, and be cost-effective, to have several types of grants funded in this area:

- **Introductory or Pilot grants.** Small, short-term grants with the explicit purpose of developing and testing out a training modality, material type, or activity.

- **Full or Regular Grants**. Full, three-year grants to implement a mix of activities designed to increase access to health care, with a budget sufficient to attract the necessary staff, and to conduct a reasonable evaluation. *If the projects do not conduct the evaluation, OMH should contract with a general or cross-site evaluator to do so.*

In addition, *OMH should consider retaining an ongoing source of technical assistance and evaluation for its grantees* to ensure evaluation consistency and quality, and to assist program development and implementation.

RECOMMENDATION SEVEN:	Develop a Technical Assistance Capacity for Culturally - Specific Program Implementation and Expand OMH Functions to Improve Dissemination of Grantee Materials

So many valuable materials have been created by OMH grantees, yet there is little evidence that the materials have been cataloged or maximally utilized by the larger community of health providers. In fact, once developed and used for the limited period of the grants, many of these materials, and strategies as well, have almost been set aside. Yet, it is from this base of materials and strategies that OMH could strengthen its hand in making recommendations for Federal or agency policy. Therefore, we recommend the following:

- OMH should take on more dissemination functions;

- OMH should expand its efforts toward a more proactive technical assistance role, linking technical assistance providers with programs or agencies needing assistance.

- Grantee staff, in fact, might serve as technical assistance providers occasionally (through the Resource Persons Network), to help other programs implement a strategy or component that they themselves had developed. This not only helps in disseminating and implementing best practices in the field, it also helps to build the capacity of those grantees who provide technical assistance.

RECOMMENDATION EIGHT:	**Building on the Bilingual/Bicultural Project Experiences, OMH Should Bring its Expertise to Bear on Current Managed Care in Public Health Issues**

OMH grantees have been deeply involved in issues of cultural competency and linguistic appropriateness of care. They have developed materials, provided interpretation services, trained health providers on cultural awareness and on the use of interpreters, translated/developed forms, and served as patient advocates and health educators. Moreover, several grantees have become directly involved in the development of local and/or state standards of care or guidelines used by managed care organizations. Based on this expertise, we believe that OMH could have an informed and effective voice in the managed care debate. *This is an arena in which OMH expertise would be of considerable value in advancing the general improvement of health care for minority populations.* For example:

- OMH should disseminate recommendations on standards of care to the National Committee on Quality Assurance (NCQA), which develops and disseminates the HEDIS standards.

- OMH should make its expertise available to Managed Care Organizations.

- OMH should work closely with HRSA and other Federal agencies involved in standards and guidelines.

RECOMMENDATION NINE:	**Support or Facilitate the Certification and Professional Development of Interpreters and Community Health Workers**

Because the issue of credibility often arose with respect to interactions between OMH grantee staff and credentialed medical professionals, OMH should actively support and promote the certification of interpreters and health educators insofar as such certification is available. Grantees and relevant professional organizations would have an interest in such certification. OMH should use its state and other contacts toward this end. Based on our experience in this study, we believe that such credentials are increasingly available—especially for (medical) interpreters—from national/regional interpretation associations.

RECOMMENDATION TEN:	Partner With Other Federal Agencies and Private Foundations that are Working Toward the Improvement of Health Care for LEP Minority Populations

At least one project has already collaborated with a HRSA-funded Area Health Education Center. In other situations, OMH-funded activities dovetailed very closely with other activities grantees were undertaking that were funded through Ryan White or the Centers for Disease Control and Prevention. Several private foundations, such as the Robert Wood Johnson and Kellogg Foundations, may be engaged in or interested in health access issues for LEP minority populations as well. It therefore makes sense for OMH to actively seek partnership and collaboration opportunities. It also makes sense for OMH to promote grantee linkage to such activities and programs. Finally, OMH should seek to have the expertise it has gained regarding multicultural populations disseminated to organizations, such as the American Medical Association, which have influence on the content of medical school curricula.

RECOMMENDATION ELEVEN:	OMH Should Use its Expertise to Leverage the Involvement of Other Agencies and Entities in Extending Health Care to LEP Populations

Evidence from the study suggests that in managing the LEP projects, OMH has helped health care professionals understand the language and cultural requirements of LEP populations with respect to accessing services. No one can deny that language absence is a barrier to accessing health care. This body of knowledge can be used by all government health agencies and in the private sector to better serve their clientele. In sharing this knowledge with other agencies, OMH not only brings to the table the mandate to serve the underserved, but also the mandate to do so with well-established practices and competencies. These practices are transferable across health and social service areas affecting the fabric of the nation's communities, and are also highly applicable to the implementation of specific initiatives, such as the President's Race Initiative.

RECOMMENDATION TWELVE: In the Grant Review Process for Programs Similar to the Bilingual/Bicultural Service Demonstration Grant Program, OMH Should Consider Key Factors that This Study Has Shown to Contribute to Program Effectiveness:

1. **Does the applicant have a demonstrated willingness to organize and collect data on the project that is realistic and useful.**
2. **A stable organizational structure and funding record to attract and retain competent staff.**
3. **A project director with a strong community base and presence in organizations that deal with the general health issues beyond the community so that they can advocate and leverage additional resources for the community.**
4. **Willingness to work with non-traditional sources and program ideas, where, if successful, the practice can have great potential for a specified population.**

Some of the most highly successful projects reviewed in the study were close to the community and influential in the wider community with respect to health issues. These projects were capable of reaching beyond the LEP community to link with networks of organizations and providers dealing with broader health issues. For example, on the issues of HIV/AIDS and cancer, we found that several project directors were able to work within task forces and policy-making bodies to become the voice of their community within those organizations.